**GOLDEN HILL INCLUSION SUPPORT TEAM**

**(GHIST)**

# **GHIST Information and Request for Support form 2024- 2025**

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| **Name of School:** | **School Number:** |
| **School Address:** | **Contact Number:** |
| **Headteacher:****SENCO:****Class Teacher:****Class/1:1 Teaching Assistant:** | **Email address:****Email address:****Email address:** |
| **Name of child:****Male/Female:** | **UPN No:** |
| **D.O.B.** | **School Year:****Attendance:****Pupil Premium:** |
| **Home Address:** | **Parent(s) names:****Address (if different)****Contact Number(s)** |
| **Ethnicity:****Home language:** |
| **CLA:** Yes/No**SGO:** Yes/No**CIN/CP: Yes/No****CAF/EHA:** Yes/No**CAF/EHA No:** | **Where is the child on the SEN Code of Practice:****EHCP status (if applicable)** |
| **Written/verbal parental permission:** Yes/No |
| **Date of referral request:** |
| **Date referral request received at Golden Hill:** |
| **Summary of concerns:** |
| **Current support and strategies in place –** (*please include outcomes/impact and what is working well)* |
| **Any other professionals or agency involvement.***E.g. CSC, CAMHS, CANW, SALT- Date of referrals* | **E.P:** Yes/No**E.P. Name:****Type of involvement:** (*EP consultation/ Full cognitive assessment)***Report date:****Review date if applicable:**  |
| **Any medical diagnosis or current investigation:** (*e.g. ASD, ADHD)* |
| **What type of support are you requesting?** *(e.g. Social skills, anger management)* |
| **What are you hoping to gain as a result of GHIST support in your setting?***(e.g. more settled and focused in class, integrating with social groups, upskilling of staff)* |
| **Please give details of any additional ‘bespoke’ support you would like and we will try to accommodate your request.**  |
| **For Golden Hill to complete only.****Start Date of support:****End Date of Support:****Outcome:****12-week GH Referral Placement Dates** (if applicable)**Start Date:****End Date:** |

Please email completed request to ghist@goldenhill.lancs.sch.uk

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